May 31st, 2007

RFS 7-99 Change Log

Below is a summary of changes made to RFS 7-99 and its attachments.

Document: RFS 7-99

- **Section 1.3, Covered Services**: deleted the word "generic"
- **Section 1.3, Covered Services:** "A $50 co-payment will apply to use of non emergency services in an emergency setting" was replaced with "A co-payment, based on income and eligibility category, will apply to emergency room services"
- **Section 1.8, Due Date for Proposals:** the due date has been changed to 3 p.m. Eastern time, Wednesday June 20th
- **Section 1.2.4, Summary of Milestones:** the due date has been changed to 6/20/2007
- **Section 2.7, Buy Indiana Initiative/Indiana Company:** Added sentence "Any respondent seeking the Buy Indiana points should include their Buy Indiana certification in their transmittal letter."

Document: Scope of Work Attachment D

- **All sections**: deleted the word "ROUGH" from document footer

- **Section 1.1.1, Buy-In Product**: replaced "In offering individuals eligible for, but unable to enroll in, the Program an opportunity to buy-into the Program, the Plan must charge premiums no greater than the capitation payment the Plan would have received from the State for providing coverage to these individuals under this RFS" with "In offering individuals eligible for, but unable to enroll in, the Program an opportunity to buy the same health insurance provided to participants in the Program, the Plan must ensure that the underwriting and rating practices applied are no different from the underwriting and rating practices used for the health insurance coverage provided to participants in the Program."

- **Section 1.6, Subcontractors**: added the clause "The State may waive its right to review subcontracts and material changes to subcontracts."

- **Section 2.0, Covered Benefits and Services**: replaced "The member will pay the remaining amount, which shall not exceed 5% of the member's income, to contribute to the premium." with "The member will pay up to 50% of the premium, not to exceed 5% of the member's income. The State will pay the remainder of the premium cost for the vision or dental insurance rider."

- **Section 2.2.1, Emergency Services:** added the clause "The Plan must cover and pay for all emergency room visits, regardless of whether the prudent layperson standard is met. Co-payments will apply to emergency room visits, as set forth in Section 2.2.3, below."

- **Section 2.2.1, Emergency Services**: replaced "unless other payment arrangements are made" with "minus any applicable co-payments."

- **Section 2.2.1, Emergency Services**: added "with the exception of applicable co-payments"

- **Section 2.2.3, Emergency Room Services Co-Payment (**formerly section title "Non-Emergency Services Obtained in an Emergency Room Setting"): replaced entire section with:

"2.2.3 Emergency Room Services Co-Payment

A co-payment will apply to emergency room services. Providers will collect the co-payment from members, and, as specified in Section 3.2.1 of this Attachment, POWER Account funds cannot be used by the member to pay the co-payment.

Childless adults will be subject to a $25 co-payment for all ER visits, both emergencies and non-emergencies.

Parents will also be subject to a co-payment for emergency room services, according to the following schedule:

- < 100% FPL - $3
- 100-150% FPL - $6
- 151-200% FPL - $25

However, the Plan must refund any co-payments paid by parents in the case of a true emergency. A true emergency will be determined using the prudent layperson standard. Only parents are entitled to a refund of the co-payment in the case of true emergencies, not childless adults.

Without interfering with member access to emergency care, Plans are encouraged to design creative strategies for reducing unnecessary emergency room utilization. Depending on the Plan's membership, example strategies could include, but are no way limited to, education and outreach, 24-hour nurse hotlines and contracting with after-hours urgent care centers."

- **Section 2.3, Preventative Care Services**: Changed the age brackets for the recommended care table from "19-35, 35-50, 60-64" to "19-34, 35-49, 50-64"

- **Section 2.4.2, Vision and Dental Services**: added "(or more)"

- **Section 2.6, Out of Network Services**: added the clause

"For family planning services, emergency medical services, nurse practitioner services and cases where the Plan is unable to provide necessary covered services within 60-miles of the member's residence by the Plan's contracted provider network, the Plan may not require an out-of-network provider to acquire a Plan-assigned provider number for reimbursement. An IHCP provider number or Federal tax ID shall be sufficient for out-of-network provider reimbursement in these cases. "

- **Section 2.9, Enhanced Services:** added "even if they have a generic substitute"

- **Section 2.10, Pharmacy Services:** replaced entire section with

"The Plan covers brand name and generic prescription drugs, and prescribed over-the-counter insulin. The following are exceptions to the coverage policy:

- Brand name and generic prescription drugs that are excluded from the Plan Description and Covered Benefits (as provided in Attachment E to the RFS) .
- Brand name and generic prescription drugs that are classified as DESI according to the Centers for Medicare and Medicaid Services.
- Brand name drugs, where generic substitution is possible, in accordance with Indiana Pharmacy Law. Brand name drugs with generic substitutes are covered if the Plan deems the brand name drug to be medically necessary or the Plan determines that the brand name drug is less costly than the generic substitute.

If the Plan implements a drug formulary with restrictions on one or more drugs in the formulary, the Plan must employ an automated system for approval of a 72-hour emergency supply of a restricted drug. The automated system must allow the pharmacist to dispense the 72-hour supply and then follow-up with the Plan or provider the next business day.

Plans are expected to develop programs and policies that maximize the utilization of generic drugs where possible and clinically appropriate.

A prescription drug formulary developed by the Plan will be subject to OMPP review and approval. "

- **Section 2.11, Cost Sharing:** replaced "$50 member co-payment for non-emergency services obtained in an emergency room setting" with "and co-payments for emergency room services"

- **Section 3.1.1, Individual Member Contributions:** in the fourth bullet, replaced "members" with "parents" and "4%" with "4.5%"

- **Section 3.1.1, Individual Member Contributions:** in the fifth bullet, replaced "members" with "childless adults"

- **Section 3.1.1, Individual Member Contributions:** deleted "As described in Section 4.1 of this Attachment, the Plan may permit individuals to make their first POWER Account contribution when they apply for the Program through the Plan. In this scenario, the Plan must not cash or deposit the money until the individual is determined to be eligible for the Program. If the individual is determined to be ineligible for the Program, the Plan

must promptly return the individual's contribution, in a timeframe to be determined by the State.

- **Section 3.2, Use of POWER Account Funds**: added "the Plan's" , "including any enhanced services the Plan may choose to offer" and "the required"

- **Section 3.2.1, Emergency Room Services** (formerly known as Non-Emergency Services): replaced entire section with "Members must be restricted from using POWER Account funds to pay for the emergency room services co-payment described in Section 2.2.3 of this Attachment."

- **Section 3.4.1.1, State Notice:** replaced

  "Promptly after determining a member has received the preventative care services recommended by OMPP, the Plan must notify the State. The Plan must also notify the State if, at the end of a coverage term, the member has not received the preventative services recommended for his or her age and gender"

  with

  "On an annual basis, the Plan must provide preventative services compliance reports to the State. The format of these reports are under development at this time, but will be expected to include a summary of member compliance and non-compliance with OMPP recommended preventative services"

- **Section 3.4.1.1, State Notice:** added " If the Plan receives claims for preventative care services after the member's account has been rolled over and amounts are credited back to the State, the Plan will not be at risk for any overpayments made to the State and the appropriate readjustments will be made"

- **Section 4.1.1, Application through the Plans**: added "Electronic signature capabilities are likely"

- **Section 4.1.1, Application through the Plans:** deleted bullet "The Plan may also estimate the individual's required POWER Account contribution during the application process and, if the Plan would like, may collect the individual's first monthly installment (which may not exceed one-twelfth (1/12) of the member's total required annual POWER Account contribution) if the individual wishes to make a payment at this time. However, if the Plan chooses to accept the payment, the Plan must not cash the individual's check or deposit the individual's money until the individual is determined to be eligible for the Program. If the individual is ultimately determined ineligible for the Program, the Plan must return the individual's payment immediately."

- **Section 4.1.1, Application through the Plans**: added "After receiving notice of DFR's final eligibility determination, the Plan may be asked to provide an eligibility notification to all individuals it assisted in applying for the Program, as well as for individuals that applied for the Program through other venues that selected, or were auto-assigned to, the Plan."

- **Section 4.1.2, Application through the State:** added "after year one"

- **Section 4.1.3, Member Enrollment in Plans:** replaced

  "After the individual's enrollment is deemed final (i.e., after the first POWER Account contribution is made), the Plan must provide a member handbook, POWER Account information, information about the recommended preventative services that apply to the member's age, gender and pre-existing conditions and a copy of the Plan policy. The policy must have a notice prominently displayed on the first page stating in substance that the member has the right to return the policy within ten (10) days of its delivery and join another plan providing services under this RFS"

  with

  "After the individual's enrollment is deemed final (i.e., after the first POWER Account contribution is made), the Plan must provide a member handbook, POWER Account information, information about the recommended preventative services that apply to the member's age, gender and pre-existing conditions, a copy of the Plan policy and a member identification card, which may also serve as the member's pre-paid debit card (as described in Section 3.3.2 of this Attachment). OMPP will establish guidelines pertaining to the standard information which must be included on the member identification card."

- **Section 4.1.5, Member Disenrollment from Plan:** replaced "Members will have a right to return the Plan's policy within ten (10) days of its delivery and join another plan providing services under this RFS" with "Members will have a right to change plans before their first POWER Account contribution is made."

- **Section 4.2.1, Marketing and Outreach:** added "the Plan's provider network,"

- **Section 4.2.2, Member Information and Education Programs:** added "and a member identification card, which may also serve as the member's pre-paid debit card (as described in Section 3.3.2 of this Attachment). OMPP will establish guidelines pertaining to the standard information which must be included on the member identification card."

- **Section 4.2.2, Member Information and Education Programs:** replaced "the $50 co-payment for non-emergency services obtained in an emergency room setting" with "Applicable co-payments for emergency room services"

- **Section 4.2.3, Cost and Quality Information**: replaced "and the copayment for non-emergency services in an emergency room setting" with "and the applicable copayments for emergency room services"

- **Section 4.2.3, Cost and Quality Information:** changed reference from "3.2.1" to "3.2.2"

- **Section 5.2.3, Specialist and Ancillary Provider Network Requirements:** Added "OMPP requires Plans to provide access to specialty care within at least 60 miles of the member's residence"

- **Section 5.2.3, Specialist and Ancillary Provider Network Requirements:** Added "or providers"

- **Section 5.2.4, Physician Extenders:** added "Among other things, these initiatives should consider quality of care and patient outcomes."

- **Section 5.2.4, Physician Extenders:** added "Any financial incentives must be positive, not punitive."

- **Section 5.7, Provider Education and Outreach:** replaced "Providers must be educated about the $50 co-payment for non-emergency services obtained in an emergency room setting." With "Providers must be educated about co-payments for emergency room services"

- **Section 5.9, Provider Payment Requirements:** added "However, the alternate payment schedule must not violate the claims payment provisions and timeframes that apply to accident and sickness insurers and HMOs under IC 27-8-5.7 and IC 27-13-36.2"

- **Section 5.11.1, Physician Pay for Performance:** added **"**Pay for performance programs should take into consideration clinical measures, patient outcomes and/or patient compliance"

- **Section 7.4.3, Claims Payment Timelines:** added **"**However, the alternate payment schedule must not violate the claims payment provisions and timeframes that apply to accident and sickness insurers and HMOs under IC 27-8-5.7 and IC 27-13-36.2."

- **Section 8.9.1, Administrative Performance Targets, Standards, and Benchmarks:** deleted requirement "No more than two (2) calls per Member Services Helpline representative should be in the queue at any time"

- **Section 8.9.1, Administrative Performance Targets, Standards, and Benchmarks:** added requirement F 3 "Member contributions via mailed paper check must be available for member use within 5 calendar days after the check has cleared. Member contributions via money order must be available for member use within 5 calendar days of payment receipt. "

- **Section 9.2.5, Non-Compliance with Performance Metrics:** Section D, added "in-network" and "an in-network"

- **Section 9.2.5, Non-Compliance with Performance Metrics: Section D,** added "In cases where the member failed to alert the in-network provider of their coverage under the Plan, however, liquidated damages will not be assessed"

Document: Responsibilities of the State Attachment F

- **Section 1.2, Member Linkage to Plans and Plan Enrollment:** replaced

  "After an individual to Plan linkage occurs, either by self-selection or auto-assignment, the State or the State's agent will inform the individual by mail of the individual's Plan selection or assignment. The Plan will also be informed, and as soon as the individual makes his or her first required contribution to the POWER Account, the member's coverage will begin."

  with

  "After an individual to Plan linkage occurs, either by self-selection or auto-assignment, the State or the State's agent will inform the Plan. As soon as the individual makes his or

her first required contribution to the POWER Account, the member's coverage will begin. After receiving notice of DFR's final eligibility determination, the Plan may be asked to provide an eligibility notification to all individuals it assisted in applying for the Program, as well as for individuals that applied for the Program through other venues and selected or were auto-assigned to the Plan."

- **Section 1.2.1, Auto-assignment to the Plan:** replaced "determined by the State and in compliance with CMS standards" with "rotating"

- **Section 1.2.1, Auto-assignment to the Plan:** added "after year one"

- **Section 1.4.2, Changing Plans**: replaced

  "after a member's initial enrollment in the Plan, the member will be permitted to return the Plan's policy within ten (10) days of its delivery and join another plan."

  with

  "individuals will also be permitted to change plans before their first POWER Account contribution is made"

- **Section 1.4.4, Disenrollment by the Member**: added bullet "Before the first POWER Account contribution is made"

Document: Plan Description and Covered Benefits Attachment E

- **Section 5.2, Primary Medical Care Providers (PMP):** deleted "obstetrics/" and "(OB/GYN)"

- **Section 6.0, Covered and Non-Covered Services** (formerly Covered and Excluded Services): deleted "generic"

- **Section 6.1, Vision and Dental Services**: replaced

  "The State will pay 50% of the premium cost for the vision or dental insurance rider. The member will pay an amount determined by OMPP, which shall not exceed 5% of the member's income."

  with

  "The member will pay 50% of the premium cost, up to 5% of the member's income. The State will pay the remaining premium cost for the vision or dental insurance rider. "

- **Table of Benefits, Outpatient Facility Section, Emergency Room row, Limitations/Co-Pay column**: replaced

  "Subject to a $50 co-payment for non-emergency services obtained in an emergency room setting."

with

"Childless adults will be subject to a $25 co-payment for all ER visits, both emergencies and non-emergencies
Parents will also be subject to co-payments according to the following schedule:

- < 100% FPL - $3
- 100-150% FPL - $6
- 151-200% FPL - $25

However, the Plan must refund co-payments paid by parents in the case of a true emergency, as determined by the prudent layperson standard. This is not true for childless adults. "

- **Table of Benefits, Ancillary Services Section, Prescription Drug row, Limitations/Co-Pay column:** replaced "Coverage limited to generic drugs, if available." with "Please see Section 2.10 of Attachment D. Subject to certain exceptions, brand name drugs are not covered where a generic substitute is available."

Document: Capitation Rates Attachment G

- **New capitation rates posted**

Document: Technical Proposal Response Template Attachment J

- **Section 4.1:** deleted bullet "Describe whether you intend to estimate individual's POWER Account contributions and initial monthly installments. If you intend to do so, describe your plan to manage this process."

Document: Cost Proposal Response Template Attachment K

- **Adjusted for new cap rates**

Document: Program Premium Documentation

- **New document posted**